

A new approach to pediatric pain management



Top left: Laura Simons, PhD, David Leslie, MD, and Penny Sullivan, PT, PCS
Bottom left: Katie Olson, PT, MSPT, Charles Berde, MD, PhD, and Judy Gaughan, RN

This summer, Children's Hospital Boston will open the Mayo Family Pediatric Pain Rehabilitation Center (PPRC) at Children's location in Waltham. The PPRC will primarily treat children with complex regional pain syndrome (CRPS), also known as reflex sympathetic dystrophy (RSD), a nerve-based pain disorder associated with hypersensitivity to touch along with circulatory changes, including coldness, skin discoloration and swelling of the affected limb(s).

Patients will spend eight hours a day in intensive rehabilitation provided by a team of physicians, psychologists and physical and occupational therapists. This will make the PPRC the most comprehensive, stand-alone day hospital program of its kind in the United States,

offering intensive, multidisciplinary rehabilitation to children and adolescents ages 7 to 18 who have not responded to traditional outpatient treatment for CRPS/RSD. The PPRC is jointly sponsored by the Division of Pain Medicine in the Department of Anesthesiology, Perioperative and Pain Medicine; the Division of Rheumatology; the Division of Psychology; and the Department of Physical and Occupational Therapy.

"For children and adolescents with this condition, there is strong evidence for effectiveness of a treatment program that combines intensive physical therapy with cognitive-behavioral therapy," says **Charles Berde, MD, PhD**, chief of Pain Medicine at Children's and executive director of the PPRC. Dr. Berde has worked for

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New center for allergic and eosinophilic disorders


Specialists from Children's Hospital Boston's Pediatric Gastroenterology and Clinical Nutrition Program and the Allergy and Immunology Program have teamed up to provide a multidisciplinary approach to the diagnosis and treatment of children with allergic gastrointestinal (GI) disorders. The Center for Allergic and Eosinophilic Gastrointestinal Disorders brings together gastroenterologists, allergists, dietitians and social support services to help children with these complex, chronic conditions.


Eosinophilic disorders occur in conjunction with elevated levels of certain white blood cells (eosinophils) in one or more parts of the digestive system. Symptoms are wide-ranging and include nausea, regurgitation or vomiting, abdominal pain and anemia. The recently described entity of eosinophilic esophagitis frequently presents with dysphagia and food impaction in children. In many instances, a biopsy is necessary to distinguish an eosinophilic-related disorder from diseases with similar presentations, such as gastroesophageal reflux disease (GERD) or inflammatory bowel disease. If a diagnosis is made, food allergy testing is essential before treatment.

There is no cure for these disorders. Children's new center will rely on its multidisciplinary team to provide effective management through dietary measures and medications that suppress eosinophils in the GI tract.

The center joins several other centers of excellence within the GI Program, including those for IBD, liver disease, celiac disease, clinical nutrition, motility and functional gastrointestinal disorders and endoscopy. The Allergy and Immunology Program cares for more than 6,000 children in New England, as well as children with rare immunodeficiencies from around the world.

 [More information on Gastroenterology: childrenshospital.org/gastro](http://childrenshospital.org/gastro)

 [More information on Allergy/Immunology: childrenshospital.org/allergy](http://childrenshospital.org/allergy)

 [More information on the American Partnership for Eosinophilic Disorders: apfed.org](http://apfed.org)




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Lactose breath testing in Lexington


The Lactose Breath Test (LBT), which confirms the diagnosis of lactose intolerance, is now available at Children's Hospital Boston at Lexington. Lactose breath testing appointments will be offered one morning per week. Our Waltham location will also be offering these tests soon.

 [Schedule an appointment: 781-672-2083 or fax the LBT requisition to 781-672-2145](#)

What's our Vector?



In April, Children's launched a new 28-page magazine called *Vector* about its research program. It will come out twice a year and showcase basic, translational and clinical research done at Children's. The first issue is dedicated to the memory of **Judah Folkman, MD**, founder and director of the Vascular Biology Program, and features several projects inspired by his vision. Other features highlight the work of **Frances Jensen, MD**, of the Department of Neurology and Program in Neuroscience, in identifying new epilepsy targets, and **Pedro del Nido, MD**, chief of Cardiac Surgery, in developing tools for beating-heart surgery. An expanded, online *Vector* is also available.

 [Check it out: childrenshospital.org/vector](#)

Expanded Sleep Center Web site




The Center for Pediatric Sleep Disorders has published an expanded Web site. New content includes virtual tours of Children's sleep labs, a glossary of sleep medicine terms and a list of frequently asked questions. The site is intended to be a resource for both primary care providers and families seeking to learn more about the diagnosis and treatment of sleep disorders in children.

 [More information: childrenshospital.org/sleep](#)

Cinemavision in Waltham

Cinemavision is a new, state-of-the-art virtual entertainment system that allows patients to watch a movie while having an MRI. A goggle-like apparatus is placed over the patient's eyes, allowing the child to watch a movie as if he/she were watching their own, personal big screen TV. "We've been able to do this with kids who would normally need sedation," says **Arnold Cyr**, MRI supervisor for Children's Hospital Boston at Waltham. "It's even helped with older kids who suffer from claustrophobia."

 [Schedule an appointment for MRI, CT, ultrasound, nuclear medicine procedure, fluoroscopy or X-ray: 781-216-1100](#)

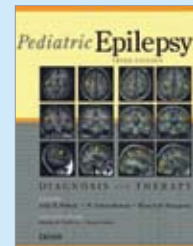
Sustaining Life



By **Aaron Bernstein, MD**, resident at Children's, and **Eric Chivian, MD**, director for the Center for Global Health and Environment at Harvard Medical School

With contributions from more than 100 scientists, this book examines the loss of Earth's biodiversity and its implications for human health. Seven groups of organisms, some of the most endangered on Earth—sharks, bears, primates, amphibians, cone snails, gymnosperms and horseshoe crabs—illustrate the contributions organisms have already made to the field of medicine, and those they could continue to make, if not driven to extinction.

Pediatric Epilepsy Diagnosis and Therapy



By **Blaise Bourgeois MD**, director of the Division of Epilepsy and Clinical Neurophysiology, and doctors **John Pellock**, **W. Edwin Dodson**, **Douglas Nordli** and **Raman Sankar**

This new edition focuses on the diagnosis, treatment, classification and management of pediatric epilepsies. Major sections are dedicated to the basic mechanisms of the disease, epidemiology, etiology, diagnosis and age-related syndromes of epilepsy.

Gift of Experience: Conversations About Hemophilia



By **Laura Gray, LICSW**, Children's social worker, and **Christine Chamberlain**

This book includes interviews with patients at the Boston Hemophilia Center who have the diagnosis of hemophilia A or B. Included are anecdotes from doctors, nurses and social workers who have cared for these patients for the past 40 years.

Generics vs. brand drugs

Reportedly, 63 percent of U.S. prescriptions are now generics, up from 18.6 percent in 1984. Given the controversy surrounding this high rate of generic prescription drug use, **Blaise Bourgeois, MD**, director of the Division of Epilepsy and Clinical Neurophysiology at Children's Hospital Boston, is actively looking into the issues. Here, he presents different sides of the argument.

How do you see the problem?

There's a disagreement between the FDA and physicians/patient advocacy groups who aren't sure generics are safe and don't consider current bioequivalence rules adequate. Between them are several groups with financial interests: companies selling brand-name drugs, those selling generic drugs, pharmacies and third-party payors. Basically, there are problems on both sides since neither has provided scientific proof and both are susceptible to influence through lobbying, political pressures or financial incentives.

What made you look into this issue?

It's something I'm confronted with every day. I'm in the business of treating patients with epilepsy so I need to know what drugs are effective for them. Pharmacies have mandatory substitution rules to switch patients to generics unless a doctor writes 'brand medically necessary' on the prescription. So either I let the pharmacists switch to generics or I don't. But I don't just request no substitutions because the next time we renegotiate with our insurers, they'll say we're prescribing too many brand names.

Do you often write "brand medically necessary?"

I did it two or three times just this week. With those patients, I feel compelled to because God forbid the child comes into the ED harmed by a seizure unrelated to the drug. I'd be in terrible trouble. How are you going to prove you did the right thing? So in a way it's defensive medicine. On the other hand, just yesterday, I switched a patient from brand name to generic. The father asked me, "Isn't generic cheaper?" and I said that it was. He asked if generics are a problem and I said, "In general, no."

Is there a reason for concern regarding generic antiepileptic drug (AED) regulations?

Definitely. Regulatory agencies established universal bioequivalence rules and never provided scientific evidence that they're safe for all classes of medications, diseases and patient populations. The FDA says generics need a 90 percent confidence level that the generic is within 80 percent below or 125 percent above the brand name's absorption rate. Much of the controversy centers on the safety and efficacy of patients being switched from brand to generic drugs. However, the main flaw I see in the current regulations isn't changing them from brand to generic or starting and maintaining a patient on a generic. It's changing them from generic A (125 percent) to generic E (80 percent), which is a pretty big margin.

Is the concern about generics' safety exaggerated?

Probably. The FDA points out, correctly, that the chance that someone would go from 125 above brand to 80 below brand is extremely low. Also, there's never been a controlled study, so reports of patients experiencing problems coinciding with substitutions are all anecdotal. How can any side be so vocal if there's no strong data? Controlled studies could very well show the problem is limited to a small group of identifiable patients.

How could this be resolved with clinical studies?

Randomized double-blind studies would either reassure patients



Blaise Bourgeois, MD, presents different sides of the brand vs. generic argument.

and physicians that current generic policies are safe or they'd provide the regulatory agencies with data they need to justify readjustments or policies and identify groups of patients at risk.

Could opinions for or against generics be amplified by those with financial interests?

Definitely. It's quite obvious there's a lot of lobbying going on and a lot of trying to manipulate opinions. It's currently very political at the state level, as reps are being lobbied by patient and physician groups with the support of brand-name pharmaceutical companies. It's been well shown that drug companies are financing many of these patient advocacy groups and that there are huge monetary contributions to these groups from companies with financial stakes. Those same contributions to regulatory agencies would be illegal. So the physician and advocacy groups are rightly criticized for being manipulated and bought by the brand-name companies. There's no doubt in my mind that a lot of the controversy around generics has been generated and kept alive by the brand-name companies.

I'm sure the generic companies aren't more honest or are more saintly than the brand-name companies, it's just that brand-names are very active. Nor can you trust insurance companies because it's obvious they're guided by saving money, not by science.

Do you think restrictions should be implemented in doctor-industry relationships?

It's hard to say what's wrong because you have to look at society in general. Look what's going on with all the lobbying of politicians in Washington. How can we say that's OK but it's not OK for pharmaceutical companies to lobby doctors? You can't ask the pharmaceutical industry to be saints when nobody else is. That said, I do think there should be restrictions to prevent doctors from being so manipulated. For example, any given company knows exactly how many prescriptions I've written for each product. They know how much any doctor prescribes and I think that's absolutely egregious.

Surgery found to cure mysterious, unexplained fevers

A child spikes a fever, as high as 104 or 105 degrees, sometimes causing seizures. She's rushed to the ED, the hospital runs test after test and specialists are brought in, but no explanation is found. Many families—though no one knows how many—go through this cyclical nightmare. The fevers come like clockwork, aren't accompanied by any obvious symptoms and don't respond to antibiotics or fever reducers. Instead, they vanish on their own after four to five days, only to return four to six weeks later.

Yet this mysterious ailment seems to have a rather simple cure. A report in the February *Archives of Otolaryngology and Head and Neck Surgery* finds tonsillectomy (with or without adenoidectomy) is almost always curative. The reason, like the illness, remains a mystery, as extensive pathology studies of the tonsils and adenoids have found no evidence of infection or abnormality. But desperate families are opting for the surgery as a last-ditch measure, and are finding it to be life-changing.

The paper, describing 27 children treated at Children's Hospital Boston from 2004 through 2006, offers the largest reported surgical experience to date with this poorly understood syndrome, known as PFAPA (periodic fever, aphthous ulcers, pharyngitis and adenitis). The children were enrolled prospectively; they ranged from 19 months to 12 years old, and many had suffered cyclical fevers for years. Twenty-six of 27 had complete fever resolution after surgery.

Greg Licameli, MD, FACS, of Children's Department of Otolaryngology, the paper's first author, has first-hand experience with PFAPA: his daughter, Claire, is described as a case report in the paper. As a toddler, she was getting fevers every 22 days that didn't respond to fever reducers. Between episodes, she seemed perfectly healthy. "She was seen by several experts at Children's," Dr. Licameli says. "The workup was always negative."

Searching the literature, he found two small reports of European children with unexplained cyclical fevers, some of whom got better after adenotonsillectomy. He decided to try it, and after Otolaryngology colleague **Dwight Jones, MD**, performed the operation, Claire's mysterious fevers disappeared. Other doctors began referring patients to Dr. Licameli, and some five years later, he's treated 60 children with PFAPA. The findings continue to hold up. "I tell parents, 'I don't know why tonsillectomy works, but it has a good chance of ridding your child of fevers,'" he says.

PFAPA was first described in the literature in 1987. Its hallmark is high fevers of a strict cyclical nature: Parents can often predict, to the day, when the fevers will arrive. Typically, fevers are the only symptom; while some children have pharyngitis, cervical lymph node enlargement and small punctate mouth ulcers, these symptoms are nonspecific and often very subtle.

The incidence of PFAPA is unknown, but Dr. Licameli believes the condition isn't all that uncommon. And its cause remains obscure. The periodicity of the fevers, their persistence over years, the lack of response to antibiotics, the aphthous ulcers and cytokine elevations during and between episodes all seem to indicate an immune dysregulation, whereas the diverse ethnic backgrounds of the patients and cure after tonsillectomy point to an infectious cause. Dr. Licameli suspects that the tonsils harbor a chronic indolent infection to which the immune system is



Greg Licameli, MD, with his daughter, Claire

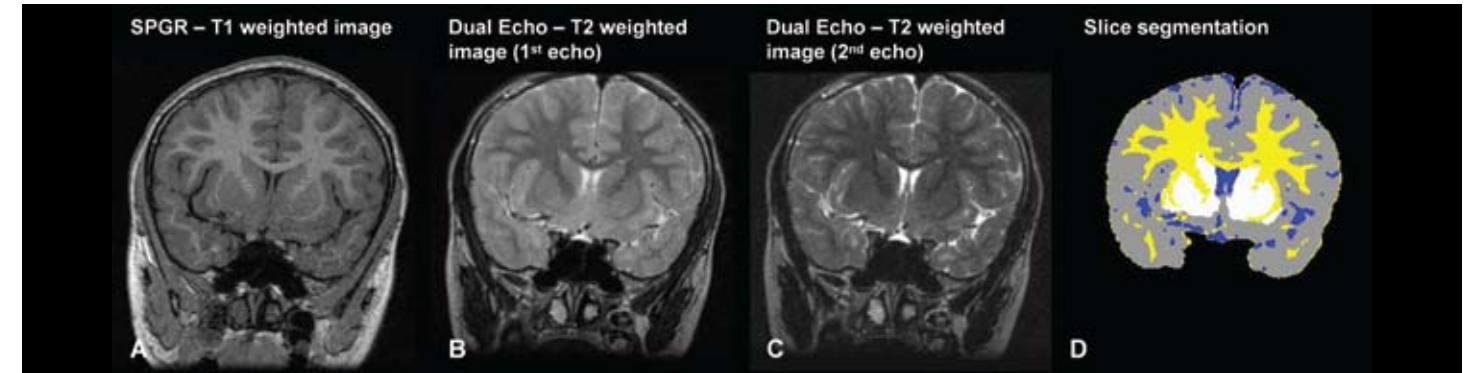
hypersensitive. He and colleagues in Children's Division of Immunology plan to investigate further.

Before considering surgery, patients should first be evaluated for rheumatologic or infectious etiologies that can also cause cyclical fever, including juvenile rheumatoid arthritis, cyclic neutropenia, familial Mediterranean fever, Behçet disease, hyperimmunoglobulinemia D syndrome and tick-borne relapsing fever. These diseases can be distinguished by careful attention to accompanying symptoms or can be ruled out with genetic markers or blood or throat cultures.

Short of surgery, early corticosteroid treatment can quickly stop fevers, but seems to make them come more frequently. One study reported success with cimetidine hydrochloride, a histamine-receptor 2 blocker, but this finding has not been replicated.

Dr. Licameli hopes his case series will increase physicians' awareness of PFAPA and allow children struggling with this condition to be offered surgery sooner. In virtually all cases, surgery has improved patients' quality of life dramatically. Parents no longer have to worry about their child suffering seizures, missing school or having to be kept away from other children because of a fever. "We have a bunch of very grateful families," Dr. Licameli says.

  [Schedule an appointment: 617-355-6460 or \[childrenshospital.org/oto\]\(http://childrenshospital.org/oto\).](#)



Brain tissue segmentation: Above, A, B and C show a single brain slice imaged in slightly different ways, and D shows the slice "segmented" by advanced software into its components (cortical gray matter, gray; white matter, yellow; subcortical gray matter, white; cerebrospinal fluid, blue). Tissue volumes for each slice are then summed to give total volumes.

Your baby's brain on drugs

More than one million babies born annually in the U.S. have been exposed to cocaine, alcohol or tobacco *in utero*. Now, an NIH-funded study led by **Michael Rivkin, MD**, of Children's Department of Neurology, suggests that these exposures have effects on brain structure that persist into adolescence.

Dr. Rivkin and colleagues at Boston Medical Center used volumetric MRI imaging to study 21 young adolescents with exposures and 14 with no exposures. Adolescents exposed prenatally to cocaine, alcohol or cigarettes had reductions in cortical gray matter and total brain volume. The sample was too small to find statistically significant effects of any single substance after adjustment for other exposures, but the more substances a child was exposed to, the greater the volume reduction. Especially noteworthy was that prenatal tobacco exposure alone had an effect on brain volume that fell just short of statistical significance. (*Pediatrics*, April 2008)

High-risk preterm infants and autism

A longitudinal study of 91 very premature newborns, weighing less than 1,500 grams at birth, finds them at increased risk for testing positive on autism screening as toddlers, even after adjustment for motor and language delays related to their prematurity. **Catherine Limperopoulos, PhD**, and **Adre du Plessis, MD**, of Children's Department of Neurology, screened the children using three well-validated assessments: the Modified Checklist for Autism in Toddlers (M-CHAT), the Child Behavior Checklist and the

Vineland Adaptive Behavior Scale. At a mean adjusted age of 22 months, 26 percent showed signs of possible autism.

Researchers conclude that early screening for autistic features is needed in preterm infants, but caution that this screening is not diagnostic and should be followed with definitive testing. "This research was done in a high-risk population of very preterm infants, and by no means are we suggesting all premature babies are at risk for autism," says Dr. Limperopoulos. "It's unclear whether these findings will persist as the children grow older." (*Pediatrics*, April 2008)

iPods safe with pacemakers

When a widely reported study last May concluded that electronic noise from iPods can make cardiac pacemakers malfunction, cardiac electrophysiologists at Children's were skeptical. "Many of our pacemaker patients have iPods and other digital music players, and we've never seen a problem," says **Charles Berul, MD**, director of the Pacemaker Service.

So Dr. Berul, cardiac fellow **Gregory Webster, MD**, and colleagues studied 51 of their own patients, placing each of four digital music players directly over the pacemaker or implantable cardioverter-defibrillator. None of the music players affected device function, and ECGs were unchanged in 255 separate tests. Players sometimes interfered with communications between the cardiac device and the programmer used to check and recalibrate it, but this interference stopped when the player was moved away.

Though reassured, doctors Berul and Webster acknowledge that their testing was short-term and suggest patients keep

iPods and other MP3 players at least six inches away from their cardiac device. (*Heart Rhythm*, April 2008)

Insight into iron deficiency

Discovery of the genetic cause of a rare disorder known as iron-refractory iron deficiency anemia (IRIDA) may give clues about more common forms of iron deficiency. **Mark Fleming, MD**, interim pathologist-in-chief at Children's, and pediatric hematologist Nancy Andrews, MD, PhD, formerly of Children's and now dean of Duke University School of Medicine, conducted a genetic search after seeing a number of children whose condition did not respond to oral or intravenous supplements, and for which no other explanation could be found. Many of the children had affected siblings.

Studies of five extended families revealed a variety of mutations in the gene *TMPRSS6*. The resulting deficiency of *TMPRSS6* protein causes the body to make too much hepcidin, inhibiting intestinal iron absorption and interfering with erythropoiesis. Because the mutations varied widely and caused different degrees of iron deficiency and anemia, doctors Fleming and Andrews believe that IRIDA might represent the extreme end of a continuum, and that more common forms of iron deficiency anemia might also have a genetic component.

The findings also suggest that stimulating *TMPRSS6* may benefit certain patients with anemia, particularly those in whom hepcidin is overproduced. Conversely, blocking *TMPRSS6* may help patients with iron overload disorders make more hepcidin, reducing intestinal iron absorption. (*Nature Genetics*, April 13, 2008)

Pediatric Health Care at Framingham Union Hospital

Wednesday, June 11, 7:30 a.m. to 12:30 p.m.

115 Lincoln St., Perini Auditorium

Framingham, MA

CME credits: 4 hours category 1 credits

Topics: ADHD, Pediatric Dermatology Updates for the PCP, Headaches: When to Treat and What are the Options?, Celiac Disease

Back to Children's Inpatient Conference


Friday, June 20, 8:00 a.m. to noon

300 Longwood Avenue, Byers A - Enders

Boston, MA

CME credits: TBD

Topics: Updates on the Inpatient Services at Children's, Youth Suicide, Too Little Too Late, Inpatient Management of Severe Constipation, Evaluation and Management of Children with Meningitis in the Era of Hib and Pevnar.

 **More information:**
617-355-7260

Michael Bresnan Child Neurology Course

September 22 to 26, 2008


Royal Sonesta Hotel

Cambridge, MA

CME credits: TBD

Fee: \$1,500; \$1,000 for residents, fellows in training and Allied Health Professionals

Objective: The objective of this course is to provide the pediatrician, family practitioner or child neurologist with the latest information in critical areas of child neurology in which scientific progress is especially fast-moving.

 **Full agendas and registration information on the above courses:**
childrenshospital.org/cme

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Pediatric pain management

more than 22 years in pediatric pain management at Children's. "We think of a partial hospital model such as the PPRC as a contemporary and cost-effective model of care," he says. "It can provide much greater intensity of treatment than outpatient care, but at a lower cost than standard tertiary hospital inpatient care."

Children with CRPS/RSD develop a vicious cycle in which pain leads them to stop moving their arm or leg, and the lack of movement produces more pain and more dysfunction and disability, according to **Michelina Cassella, PT**, director of the Department of Physical and Occupational Therapy. "CRPS/RSD is a unique condition because you have to find a way to help the patient relearn the use of their painful limb, and getting them to move that limb is the key to treatment," she says. "This involves retraining the brain along with retraining the limb." On-site staffing of physical therapy services for the PPRC is provided primarily by **Melinda Hogan, PT**, and **Katie Olson, PT, MSPT**.

Deirdre Logan, PhD, clinical assistant in Psychology and director of Psychological Services for Pain Medicine and the PPRC, says the goal of the center is to restore children to normal functioning while managing their pain. "A lot of these kids become 'functioning disabled' by the pain," she says. "They're not able to participate in normal activities, like going to school or playing. Our purpose is to take kids who have been living in pain for a long time and get them functioning. One route to restoring functioning is to help them learn to self-manage pain and increase activity by changing how they think about pain and teaching them to use behavioral tools. In a lot of cases, once they're functioning again, we also start to see some reduction in pain." On-site staffing of psychological services for the PPRC is provided primarily by **Laura Simons, PhD**, and **Gloria Chiang, PhD**.

As a component of helping children return to normal functioning, the center will offer patients one hour per day of academic instruction provided by an outside tutoring company, Education, Inc.

"With tutoring, they don't fall behind in school work, which can be a tremendous added stress to these children," says **Judy Gaughan, RN**, clinical coordinator of the PPRC.


Unlike some other pediatric hospitals' pain rehabilitation programs, the PPRC will have a large psychology and biobehavioral therapy component. "It's wonderful to offer children treatment that allows them to go home and be with their families at night, practice their functioning skills and gain support from their families," says **David Leslie, MD**, on-site clinical director. Along with Dr. Leslie, additional on-site physician coverage will be provided by Dr. Berde and by **Alyssa Lebel, MD**,

"For children and adolescents with this condition, there is strong evidence for effectiveness of a treatment program that combines intensive physical therapy with cognitive-behavioral therapy."

— **Charles Berde, MD, PhD**

senior associate in Pain Medicine and Neurology, **Navil Sethna, MB, ChB**, senior associate in Perioperative Anesthesia and Pain Medicine, and **Susan Sager, MD**, senior associate in Perioperative Anesthesia and Pain Medicine.

There's also a research component to the program. **David Borsook, MD**, and **Lino Becerra, PhD**, are neuroscience researchers jointly appointed at Children's, McLean Hospital and Massachusetts General Hospital. Along with Dr. Lebel and others, they are investigating the effect of CRPS on child and adolescent brains using functional magnetic resonance imaging (fMRI). "Pain is unique in kids," says Dr. Borsook. "We're exploring how the brain changes or adapts, both when pain persists and when pain resolves." Like the PPRC, the pain imaging fMRI research program has received funding from the Mayo Family.

 **Schedule an evaluation:** 617-355-8930
More information: 781-216-1650



Michael Agus, MD, has been named medical director of the Medical Intensive Care Unit (MICU) and director of the Medicine Critical Care Program in the Department of Medicine, while remaining medical director of the Intermediate Care Program (ICP). Dr. Agus has been at Children's since starting his internship in 1995. He completed fellowships in both Pediatric Critical Care at Massachusetts General Hospital and Pediatric Endocrinology at Children's, and spent time on faculty at Boston Medical Center in the PICU before establishing the ICP in 2003. His primary research focuses on tight glycemic control in post-operative cardiac surgery babies.



Peter Wolff, MD



Steve Colan, MD

Peter Wolff, MD, recently stepped down as the chair of Children's Institutional Review Board (IRB) after 35 years of service. During that time, he guided the hospital through an immense amount of change on the research front. Dr. Wolff will stay on as vice chair, while **Steve Colan, MD**, chief of Non-invasive Cardiology, will become chair of the IRB.



Mohamed Sayegh, MD, director of Research in the Division of Nephrology, is the recipient of the 2008 AST/Wyeth Mentoring Award by the American Society of Transplantation (AST). The AST Awards and Grants Committee chose Dr. Sayegh as the first recipient of this newly established award for being an outstanding mentor and for his dedication in shaping the career paths of many individuals who trained in transplantation under his guidance.



Gerald Healy, MD, otolaryngologist-in-chief, is being awarded an Honorary Fellowship by the Royal College of Surgeons of England in July. The award is recognition of his contributions to the field of otolaryngological surgery.



Todd Golub, MD, who is on staff at Children's and the Dana-Farber Cancer Institute, recently won the prestigious E. Mead Johnson Award for Research in Pediatrics. The award honors clinical and laboratory research achievements in pediatrics. Thirty percent of all recipients of this award either trained at or were on staff at Children's.



Holcombe Grier, MD, associate chief of Pediatric Clinical Oncology, won the 2008 HMS Faculty Prize for Excellence in Teaching (Years III and IV), the biggest honor one can receive for clinical student teaching.

Q: What is your view on circumcision?

A: The position of the AAP remains that there are both risks and benefits of circumcision, and that parents should decide after discussing these issues with their pediatrician. The risks of newborn circumcision are largely those of surgical complications, primarily bleeding. Although the overall complication rate has been reported to be 2 to 3 percent, most of these are minor, and serious injury to the penis and life-threatening hemorrhaging are rare. The technical challenges of newborn circumcision are widely under-appreciated, and a significant (but unknown) number of boys end up undergoing revision of their circumcision. Although claims are often made that circumcision negatively impacts sexual function or satisfaction later in life, few data support this.


The possible benefits of circumcision continue to be subject to debate, but potential benefits include near-elimination of the lifetime risk of penile cancer, reduction in risk of UTI during infancy and reduced incidence of balanitis and phimosis. There have also been a number of studies suggesting that circumcised men are less likely to acquire and transmit a variety of sexually transmitted diseases. The most dramatic recent development with respect to this were the results of two randomized controlled trials showing that adult circumcision of men in sub-Saharan Africa reduced HIV transmission dramatically. Even though these studies do raise new questions (Do the findings

apply to newborn circumcision? Do they apply to HIV transmission in developed countries? Is the risk of non-HIV STDs lower after circumcision?), this is the first time that any urological surgical procedure has been conclusively demonstrated to positively impact survival.

Newborn circumcision continues to be highly prevalent in most parts of the United States. When performed by experienced physicians, the complication rate is low and cosmetic and functional results are excellent. Although newborn circumcision continues to be an elective procedure and not without risk, it seems increasingly likely that there are also measurable medical benefits associated with it.



-Caleb Nelson, MD, MPH, assistant in Urology

 [More information:
childrenshospital.org/urology](http://www.childrenshospital.org/urology)

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Children's Hospital Boston



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